

Healthpoint

Information from the Division of Health Care Finance and Policy

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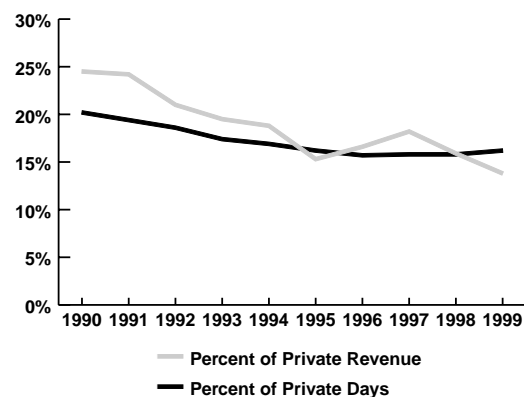
EMERGING TRENDS IN LONG-TERM CARE

Historically, nursing homes have been the main provider of long-term care for the elderly, but in recent years the array of long-term care settings has expanded dramatically. Consumers increasingly receive services in assisted living facilities, adult day health programs, and their own homes. While these changes have generally benefited the consumer, they have altered the face of the nursing home industry. Alternate settings, most notably assisted living facilities, have been successful at attracting private paying elders, formerly a key source of revenue for nursing homes. This issue of *Healthpoint* examines recent trends in nursing home use, the effect of changing market dynamics and future financing of long-term care.

Healthier and Wealthier Seniors Are Choosing Assisted Living

A recent study of data from the 1995 National Nursing Home Survey showed an 8.2% decline in the ratio of persons ages 65 and over residing in nursing homes between 1985 and 1995.¹ This same study also noted the decline in the proportion of patients paying privately for their care—44% in 1985 to 28% in 1995. Similar dramatic changes occurred in Massachusetts. Between 1990 and 1999, the population of Massachusetts residents ages 65 and over increased 5%, but the total number of nursing home days declined 3%.² Furthermore, there was a decline in the proportion of privately paid patient days in Massachusetts nursing facilities, from 20.2% in 1990 to 16.2% in 1999 (see figure right). Even more dramatically, the percent of revenue from private sources declined a startling 43.7% from 24.5% in 1990 to 13.8% in 1999.³ So, as nursing home use has declined overall, there has been an even steeper decline in the share of private paying patients. These patients are important to nursing homes, in large part because they usually pay full charges for their care, unlike the Medicare and Medicaid programs which typically pay less for the patients they cover.

Percent of Private Days and Revenue
for Massachusetts Nursing Homes by Year



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Seniors who even ten years ago probably would have entered a nursing home now can often choose a less institutional alternative. In particular, people who once would have paid privately for nursing home care (usually wealthier patients who are less frail than average) are now more likely to reside in assisted living facilities. Growth in the assisted living market has been tremendous. In 1990, there were fewer than 30 assisted living facilities in Massachusetts. Today, there are 151 such facilities with nearly 9,000 residence units.⁴ Assisted living facilities differ from nursing homes in several important ways. First, assisted living does not provide any of the skilled nursing supervision that nursing homes do.⁵ Assisted living offers only supportive services to elderly residents, including assistance with medication administration and meal preparation.

A second key difference between nursing homes and assisted living facilities is their primary source of revenue. Under the Medicaid program, nursing home care is a covered service for those seniors poor enough to qualify. In Massachusetts, Medicaid pays for approximately 70% of nursing home patient care days. Unlike nursing home care, assisted living is generally not paid for under any public program.⁶ According to a 1997 survey by the Massachusetts Assisted Living Facilities Association, close to 64% of the residents pay for assisted living using only their own assets and income; another 16% have financial support from their family; the remaining 20% did not provide information. Many elderly supplement the services of assisted living with home health services, increasing their costs but also postponing or, in some cases, permanently averting admittance to a nursing home. The cost of assisted living varies, ranging from \$1,900 to \$5,000 a month, with the average one bedroom apartment (with services) costing \$3,200 per month.⁷ Nursing homes in Massachusetts charge approximately \$6700 per month to private paying residents.⁸ The higher cost of nursing home care is due to the higher level of care, primarily skilled nursing supervision, provided.

An important question that has yet to be answered is: what will happen to the healthier, wealthier and younger senior population in assisted living as it ages further? Will some residents eventually enter nursing homes continuing to pay out of pocket or after spending down to Medicaid eligibility? Alternatively, will some residents privately purchase ever increasing levels of care with assisted living facilities gradually becoming de facto nursing homes?

Nursing Homes Are Treating a Different Mix of Patients

The emergence of assisted living facilities is just one factor that has changed the population of nursing homes. Another trend is the sharp increase in end of life care now provided by nursing homes. Some patients have lived in nursing homes for years and die there foregoing hospital services; others are admitted near death from hospitals when acute interventions are discontinued. In

Site of Death, Massachusetts Residents		
	1992	1999
Hospital	57.9%	45.9%
Nursing Home	19.2%	30.2%

Source: Department of Public Health

seven years, the site of death for Massachusetts residents has shown a dramatic shift away from hospitals to nursing homes, with other sites (home, hospice, out of state) remaining relatively constant.

Another key change for nursing homes is the increase in the number of short-term patients admitted from hospitals for rehabilitation services. Medi-

care pays for up to 100 days of rehabilitation following an acute hospital discharge. While rehabilitation patients are generally younger and less chronically ill than long-term nursing home patients, they are being transferred after shorter hospital stays than ever before⁹ and they are coming for more intensive, expensive services such as physical and occupational therapy.

These changes in payer and patient mix have expanded the role of nursing homes beyond their traditional role of serving the chronically ill. Reduced demand overall for nursing home services, their increasingly high-demand patient mix, and the migration of their private paying clientele have all contributed to the current poor financial health of the nursing home industry. Further, the growing cost of nursing home care to state Medicaid budgets and the aging of the baby boomers have all brought greater urgency to creating viable private financing mechanisms for long-term care.

Options for Future Financing of Long-Term Care

There are some solutions for private long-term care financing, however, greater use of any of these mechanisms would require a significant change in public attitude and perception. Most individuals do not perceive that they need long-term care coverage, mistakenly thinking that the Medicare program will cover those needs. Instead, those who do not prepare often end up spending down their assets to become eligible for public assistance through Medicaid. If private solutions are to become a key part of the financing picture for long-term care, then individuals must plan for and assume greater responsibility for their future long-term care needs during their working years.

Three financing mechanisms for long-term care include long-term care insurance (LTCI), certain life insurance products, and viatical settlements. While none of these mechanisms will help the nursing home industry regain the less frail private paying patients lost to assisted living, they would likely benefit the industry by lessening its reliance on tax-funded government programs. Greater use of private funding will help state Medicaid budgets, since Medicaid funds most long-term care today. Individuals who plan ahead and use one of these financing mechanisms would also benefit since they may preclude or at least reduce the need to spend down assets to qualify for Medicaid.

Currently, less than 1% of all employers with 10 or more employees sponsor LTCI nationally¹⁰ and virtually none subsidize the cost as they widely do for health insurance. However, the federal government has taken the innovative step of sponsoring LTCI for its employees, expected to begin in October of 2002. This will create the largest employer-sponsored LTCI offering in the country.

With limited employer sponsorship of LTCI, the burden rests with individuals to purchase policies. The cost of such policies varies widely depending on the benefits chosen and the age of the purchaser. If purchased at age 55, an LTCI policy may cost less than \$1000 per year; by age 75, the policy could cost up to \$6,000 per year.¹¹ Experts also say that greater acceptance of this insurance at least partially hinges upon benefits being usable across various long-term care settings, a feature which is not always available in such policies currently. Despite these obstacles, the number of persons covered by long-term care insurance nationwide grew by approximately 140% between 1992 and 1998, from 1.7 million to 4.1 million.¹²

However, if one does not use one's long-term care insurance benefits, the money spent on the policy is gone. Some life insurance policies contain provisions that address this drawback. These policies have an accelerated death benefit that under certain circumstances allows the insured to receive monies from the policy that can be used to finance long-term care. Whether paid in a lump sum or in periodic installments, each payment received reduces the death benefit payable to the insured's beneficiaries. The rules and costs of such riders vary widely.

Viatical settlements gained prominence as a means for AIDS patients to finance their end of life care. It is an arrangement whereby a third party, usually a broker, purchases ownership of a life insurance contract covering a terminally ill insured. The percentage paid (usually 50-80% of the death

benefit) is inversely related to the insured's life expectancy. The disadvantage of a viatical settlement is that the benefits are time limited and leave the beneficiary without a survivor payment.

These private financing products require investment, planning, and consumer research to find the right match for the individual circumstance. Unlike employer-based health insurance, consumers are without an intermediary to sift through competing products. The wide array of choices between these alternatives and within the policies themselves presents a confusing challenge to potential consumers.

Conclusion

Over the last decade, there have been dramatic changes in the delivery of long-term care. But the biggest challenge is looming on the horizon. By 2025, the over age 85 population in Massachusetts is projected to grow by nearly 40% from 114,000 to 158,000. Access to a wide array of quality long-term care services and a viable funding mechanism will become a priority for this segment of the populace long before then. Innovative solutions involving both public and private sectors must be considered and developed now, to ensure quality, affordable long-term care for tomorrow's seniors.

Endnotes

1. Bishop, Christine E. "Where are the Missing Elders? The Decline in Nursing Home Use, 1985 and 1995." *Health Affairs*, July/August 1999.
2. Division of Health Care Finance and Policy HCF-1 nursing home cost report data, 1990-1999. U.S. Census data, 1999.
3. Division of Health Care Finance and Policy HCF-1 nursing home cost report data. 1990-1999.
4. Massachusetts Assisted Living Facilities Association, 1997 Residence Survey, <http://www.massalfa.org> and data from the Massachusetts Executive Office of Elder Affairs, <http://www.state.ma.us/elder>.
5. Massachusetts state law prohibits assisted living facilities from admitting any resident who requires twenty-four hour skilled nursing supervision, unless a certified home health agency provides the care, but such supervision generally may not exceed more than ninety days a year.
6. The Group Adult Foster Care Program administered by the Massachusetts Division of Medical Assistance covers a portion of the costs for some lower-income residents. In addition, there is a specific category of Supplemental Security Income (SSI) that covers the room and board expenses for eligible residents.
7. Massachusetts Assisted Living Facilities Association, Residence Survey from 1997 and 2001, <http://www.massalfa.org>.
8. Division of Health Care Finance and Policy HCF-1 nursing home cost report data, 1999.
9. The median length of stay of elders discharged from hospitals to nursing homes dropped a full day from 1996 to 1999. Division of Health Care Finance and Policy hospital case mix discharge data.
10. Employee Benefit Research Institute. *EBRI Issue Brief*, "Employer-Sponsored Long-Term Care Insurance: Best Practices for Increasing Sponsorship," April 2000.
11. American Association of Retired Persons 1997-1998 data, <http://www.aarp.org/contacts/health/privlhc.html>.
12. United States General Accounting Office testimony before the Committee on Finance, United States Senate, "Long-Term Care: Baby Boom Generation Increases Challenge of Financing Needed Services," March 27, 2001.

Did you know?

Higher Volume Lowers Risk

The Leapfrog Group, a consortium of major US health care purchasers, is in the forefront of a number of initiatives aimed at optimizing medical outcomes. One of their efforts draws upon several studies showing that for the five high risk surgical procedures listed below, significantly better clinical outcomes are associated with hospitals that perform more than a threshold number each year. While hospital data show that most people undergoing these procedures in Massachusetts are having them done in high volume hospitals, this is not the case for everyone. The table below shows what percentage of these procedures performed in Massachusetts in FY99 took place in a high volume hospital.

Procedure	Threshold Volume Recommended	Percent Performed in Mass. Hospitals that Meet Threshold
Coronary Artery Bypass Graft	500 or more per year	80%
Coronary Angioplasty	400 or more per year	99%
Carotid Endarterectomy	100 or more per year	43%
Abdominal Aortic Aneurysm Repair	30 or more per year	75%
Esophageal Cancer Surgery	7 or more per year	62%

Source: Division of Health Care Finance and Policy

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